

DEPARTMENT OF HEALTH
REGISTRATION NUMBER
3702
3702

CERTIFICATE OF DEATH

LOCAL REGISTRAR COPY

RESIDENCE		MIDDLE LAST						2. SEX: <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE	3A. DATE OF DEATH: <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR	3B. HOUR: <input checked="" type="checkbox"/> 10:02 p.m.			
NCHS		Ronald D. Smith						<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 12 <input checked="" type="checkbox"/> 05 <input type="checkbox"/> 2016			
4A. PLACE OF DEATH: <input type="checkbox"/> HOSPITAL <input type="checkbox"/> HOSPITAL OUTPATIENT <input type="checkbox"/> HOSPITAL INPATIENT <input type="checkbox"/> NURSING HOME <input type="checkbox"/> PRIVATE RESIDENCE <input type="checkbox"/> HOSPICE FACILITY <input type="checkbox"/> OTHER (Specify):								4D. IF FACILITY, DATE ADMITTED: <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR					
4C. NAME OF FACILITY: (If not facility, give address)		St. Luke Health Services						4D. LOCALITY: (Check one and specify) CITY VILLAGE TOWN Oswego			4E. COUNTY OF DEATH: Oswego		
4F. MEDICAL RECORD NO. A-7628		4G. WAS DECEASED TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state)						4H. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH: University Hospital Syracuse, NY Onondaga Co					
5. DAY OF BIRTH: 05 17 1984		6A. AGE IN YEARS: 32 yrs.		6B. IF UNDER 1 YEAR: ENTER: months		6C. IF UNDER 1 DAY: ENTER: days hours minutes		7A. CITY AND STATE OF BIRTH: (If not USA, Country and Region/Province) Oswego, NY		7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:			
6. SERVED IN U.S. ARMED FORCES? (Specify years) <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> 0 <input type="checkbox"/> 1		9. DECEASED OF HISPANIC ORIGIN? Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino. <input checked="" type="checkbox"/> A No, not Spanish/Hispanic/Latino <input type="checkbox"/> B Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> C Yes, Puerto Rican <input type="checkbox"/> D Yes, Cuban <input type="checkbox"/> E Yes, Other Spanish/Hispanic/Latino (Specify)						10. DECEASED'S RACE: Check one or more races to indicate what the decedent considered himself or herself to be: <input checked="" type="checkbox"/> A White/Caucasian <input type="checkbox"/> B Black or African American <input type="checkbox"/> C Asian Indian <input type="checkbox"/> D Chinese <input type="checkbox"/> E Filipino <input type="checkbox"/> F Japanese <input type="checkbox"/> G Korean <input type="checkbox"/> H Vietnamese <input type="checkbox"/> J Native Hawaiian <input type="checkbox"/> K Guamanian or Chamorro <input type="checkbox"/> M Samoan <input type="checkbox"/> N American Indian or Alaska Native (Specify) <input type="checkbox"/> P Other Asian (Specify) <input type="checkbox"/> Q Other (Specify)					
7A. DECEASED		11. DECEASED'S EDUCATION: Check the box that best describes the highest degree or level of school completed at the time of death. <input type="checkbox"/> 1 5th grade <input type="checkbox"/> 2 9th-12th grade, no diploma <input checked="" type="checkbox"/> 3 High school graduate or GED <input type="checkbox"/> 4 Some college credit, but no degree <input type="checkbox"/> 5 Associate's degree <input type="checkbox"/> 6 Bachelor's degree <input type="checkbox"/> 7 Master's degree <input type="checkbox"/> 8 Doctoral/Professional degree						12. SOCIAL SECURITY NUMBER: 405-27-2111 13. MARITAL STATUS: NEVER MARRIED <input checked="" type="checkbox"/> 1 MARRIED <input type="checkbox"/> 2 WIDOWED <input type="checkbox"/> 3 DIVORCED <input type="checkbox"/> 4 SEPARATED <input type="checkbox"/> 5				14. SURVIVING SPOUSE: Enter birth name of spouse if married or separated.	
15A. USUAL OCCUPATION: (Do not enter retired) Certified nurse's aide		15B. KIND OF BUSINESS OR INDUSTRY: Healthcare						15C. NAME AND LOCALITY OF COMPANY OR FIRM: St. Luke Health Services					
16A. RESIDENCE: (State or Country if not USA) NY		16B. County or Region/Province: If not USA: Oswego		16C. LOCALITY: (Check one and specify) CITY VILLAGE TOWN <input checked="" type="checkbox"/> Fulton		16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF NO, SPECIFY TOWN:							
18D. STREET AND NUMBER OF RESIDENCE: 91 Kings Rd								16E. ZIP CODE: 13069		Volney			
17. BIRTH NAME OF FATHER / PARENT: DAVID		18. BIRTH NAME OF MOTHER / PARENT: Smith		19. NAME OF INFORMANT: Denise Smith						19B. MAILING ADDRESS: (Include zip code) 91 Kings Rd. Fulton, NY 13069			
20A. 1 <input type="checkbox"/> BURIAL 2 <input type="checkbox"/> CREMATION 3 <input type="checkbox"/> REMOVAL MONTH <input type="checkbox"/> DAY <input type="checkbox"/> 5 <input type="checkbox"/> DONATION YEAR <input type="checkbox"/> 6 <input type="checkbox"/> ENTOMBMENT 12 06 2016		20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: Traub Crematorium						20C. LOCATION: (City or town and state) Central Square, NY					
21A. NAME AND ADDRESS OF FUNERAL HOME: Sugar & Scanlon Funeral Home 147 W. 4th St. Oswego, NY 13126								21B. REGISTRATION NUMBER: 01642					
22A. NAME OF FUNERAL DIRECTOR: Theresa A. Sugar Scanlon		22B. SIGNATURE OF FUNERAL DIRECTOR: Theresa A. Sugar Scanlon						22C. REGISTRATION NUMBER: 13496					
23A. SIGNATURE OF REGISTRAR: Rita A. Traub 12 06 2016		23B. DATE FILED: MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		24A. BURIAL OR REMOVAL PERMIT ISSUED BY: Rita A. Traub		24B. DATE ISSUED: MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR							
ITEMS 25 THRU 38 COMPLETED BY CERTIFYING PHYSICIAN -- OR -- CORONER/CORONER'S PHYSICIAN OR MEDICAL EXAMINER													
25A. CERTIFICATION: To the best of my knowledge, death occurred at the time, date and place and due to the causes stated.													
Certifier's Name: Sandra A. Ford N.P.		License No.: 330672		Signature: Sandra A. Ford		Month <input type="checkbox"/> Day <input type="checkbox"/> Year							
Cancer		Certifier's Title: <input type="checkbox"/> Attending Physician <input type="checkbox"/> Physician acting on behalf of Attending Physician <input type="checkbox"/> Coroner <input checked="" type="checkbox"/> Medical Examiner / Deputy Medical Examiner		Address: 299 E. River Rd, Oswego, NY 13126		Month <input type="checkbox"/> Day <input type="checkbox"/> Year							
CERTIFIER		25B. If coroner is not a physician, enter Coroner's Physician's name & title:		License No.:		Signature:							
25C. If certifier is not attending physician, enter Attending Physician's name & title:		License No.:		Address:									
26A. Attending physician attended deceased: FROM 08 16 2016 TO 12 05 2016		26B. Decedent last seen alive by attending physician: 12 05 2016		26C. Pronounced dead ON 12 05 2016		Month <input type="checkbox"/> Day <input type="checkbox"/> Year							
27. MANNER OF DEATH: NATURAL CAUSE <input checked="" type="checkbox"/> ACCIDENT <input type="checkbox"/> HOMICIDE <input type="checkbox"/> SUICIDE <input type="checkbox"/> UNDETERMINED CIRCUMSTANCES		28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> REFUSED		29A. AUTOPSY? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> REFUSED		29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES							
DUE TO OR AS A CONSEQUENCE OF: (A) Respiratory arrest - palliative care status minutes		(B) AIDS 3 years		(C)									
DUE TO OR AS A CONSEQUENCE OF: (A)		SEE INSTRUCTION SHEET FOR COMPLETING CAUSE OF DEATH						CONFIDENTIAL					
30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C))													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART I. IMMEDIATE CAUSE: (A) Respiratory arrest - palliative care status minutes													
(B) AIDS 3 years													
DUE TO OR AS A CONSEQUENCE OF: (C)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A): Aspirine, HIV Encephalopathy								DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> PROBABLY <input type="checkbox"/> UNKNOWN					
31A. IF INJURY, DATE: MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		31B. INJURY LOCALITY: (City or town and county and state)		31C. DESCRIBE HOW INJURY OCCURRED:		31D. PLACE OF INJURY:		31E. INJURY AT WORK? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES					
31F. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian		32. WAS DECEASED HOSPITALIZED IN NO YES <input type="checkbox"/> 0 Not pregnant within last year <input type="checkbox"/> 1 Pregnant at time of death <input type="checkbox"/> 2 Not pregnant, but pregnant within 42 days of death		33A. IF FEMALE: <input type="checkbox"/> 0 <input checked="" type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17 <input type="checkbox"/> 18 <input type="checkbox"/> 19 <input type="checkbox"/> 20 <input type="checkbox"/> 21 <input type="checkbox"/> 22 <input type="checkbox"/> 23 <input type="checkbox"/> 24 <input type="checkbox"/> 25 <input type="checkbox"/> 26 <input type="checkbox"/> 27 <input type="checkbox"/> 28 <input type="checkbox"/> 29 <input type="checkbox"/> 30 <input type="checkbox"/> 31 <input type="checkbox"/> 32 <input type="checkbox"/> 33 <input type="checkbox"/> 34 <input 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City of Oswego, New York

REGISTRAR

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THIS IS TO CERTIFY that the foregoing is a true and correct transcript of the RECORDS in the OFFICE of the REGISTRAR of VITAL STATISTICS of the City of Oswego, New York, and of the whole thereof.